

# Work Capacity Evaluation Musculoskeletal Conditions

## U.S. Department of Labor

Employment Standards Administration  
Office of Workers' Compensation Programs



Injured Worker's Name ( <i>First, middle, last</i> )	OWCP No.	OMB No: Expires:	1215-0103 08-31-2005
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Please answer the questions below concerning your patient (named above) for whom the Office of Workers' Compensation Programs (OWCP) has accepted the following conditions:

1a. Is the worker capable of performing his/her usual job? ☐ Yes ☐ No. If no, please explain.

### Many employers can readily accommodate medical restrictions including assignment of the injured worker into an alternative work location.

b. If the claimant is unable to perform his/her usual job, is the claimant able to work for 8 hours per workday with restrictions? ☐ Yes ☐ No. If no, please provide medical reasons to support your opinion.

c. If less than 8 hours per workday, how many can he/she work?

d. Do you anticipate an increase in the number of hours this person will be able to work? ☐ Yes ☐ No

e. If yes, when will this person achieve an 8 hour workday? If no, please provide medical reasons to support your opinion

f. How long will the restrictions apply?

g. Has maximum medical improvement been reached? ☐ Yes ☐ No.

2. Please indicate whether this person has any **LIMITATION** in the activity listed and how many hours this person can perform each activity. If there are limitations in lifting, pulling and/or pushing, please provide the maximum number of pounds that can be handled by this person.

Activity	Limitation	# of Hours Able to Work	Activity	Limitation	# of Hours Able to Work	Lbs.	
Sitting	<input type="checkbox"/> Yes		Repetitive Movements:				
Walking	<input type="checkbox"/> Yes			Wrists	<input type="checkbox"/> Yes		
Standing	<input type="checkbox"/> Yes			Elbow	<input type="checkbox"/> Yes		
Reaching	<input type="checkbox"/> Yes		Pushing	<input type="checkbox"/> Yes			
Reaching above			Pulling	<input type="checkbox"/> Yes			
Shoulder	<input type="checkbox"/> Yes		Lifting	<input type="checkbox"/> Yes			
Twisting	<input type="checkbox"/> Yes		Squatting	<input type="checkbox"/> Yes			
Bending/Stooping	<input type="checkbox"/> Yes		Kneeling	<input type="checkbox"/> Yes			
Operating Motor Vehicle at work	<input type="checkbox"/> Yes		Climbing	<input type="checkbox"/> Yes			
Operating a Motor Vehicle to/from work	<input type="checkbox"/> Yes		Breaks:				
			Duration		Frequency		
			Duration		Frequency		

3. Are there **OTHER** medical facts, situational factors, equipment or devices which need to be considered in the identification of a position for this person? If so, please explain.

4. Physician's Name (*Type or print*)

5. Telephone

6. Signature

7. Date

The information requested will assist OWCP in determining eligibility to benefits and is required to obtain or retain a benefit. (5 USC 8101 et. seq.)

### Public Burden Statement

We estimate that it will take an average of 15 minutes per response to complete this information collection including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

**DO NOT SEND THE COMPLETED FORM TO THE OFFICE SHOWN ABOVE.**

**Form OWCP-5c**  
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